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Opinions About Mental Illness

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Abstract

Negative stereotypes and stigmatizing attitudes against mentally ill persons have powerful historical roots in many cultures. The common perception of these persons, who are unable to defend their rights, is that they are dangerous, violent and unpredictable (Arboreda-Florez & Sartorius, 2008). This paper presents a preliminary investigation regarding the public perceptions and attitudes about mental illness using an adapted version of the Opinions about Mental Illness Scale (Cohen & Struening, 1962). The participants were 150 university students and the following five attitudinal dimensions were investigated: authoritarianism (the opinion that people with a mental illness cannot be held accountable for their acts and they should be controlled by society), benevolence (an attitude that could be placed between tolerance and pity/compassion), mental hygiene ideology (the opinion that mental illness is similar to other illnesses and it should be treated adequately by specialists), social restrictiveness (the opinion that mentally ill persons should be restricted in some social domains), and interpersonal aetiology (the belief that the real cause of a mental illness are the problematic interpersonal relations). The implications for the implementation of anti-stigma programs are discussed.

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Keywords: Social Perception of Mental Illness, Stigma of Mental Illness, Attitudes Toward Mental Illness.

1. Introduction

According to epidemiological studies conducted in Europe and in the United States, mental illnesses are common characteristics of our urban societies. Their frequency is estimated at almost one fourth of the general population in most countries. In other words, one of four people is expected to report sufficient criteria to be diagnosed with a form of mental illness at some point in his/her life (Alonso, Angermeyer, & Bernert, 2004; Kessler, Chiu, Demler, & Walters, 2005). Beside these statistical data, mental illness is still a cause of stigmatization, social rejection and isolation in contemporary society, otherwise very open to discussing topics that used to be considered taboo (e.g. homosexuality, AIDS, racial differences, equal opportunities for ethnic minorities). Despite the remarkable progresses reported in the last decades in psychiatry and psychotherapy

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regarding the prevention and therapy of mental disorders, the image of the dangerous mad man, the image of the dark asylum or the feelings of loneliness and alienation associated with the mentally ill, very present during centuries in popular culture and in art, are still vivid in our minds and they are able to stimulate our imagination. Recent studies conducted in various cultural contexts indicate that the ancient stigma associated with mental illness is still present in the most part of population. Mentally ill people are viewed as irresponsible, unable to control themselves, incurable, irremediably lost for the society, dangerous or a subject of mercy and compassion, living in their own mysterious and isolated worlds (e.g. Corrigan et al., 2001; Chung, Chen, & Liu, 2001; Mahto et al., 2009; Mehta et al., 2009; Kazantzis et al., 2009). As a consequence, they feel isolated, rejected by their families, friends and by the community, useless, unable to reintegrate in society. They feel fear and despair because nobody is willing to listen to their voices which lead to considerable lack of motivation and to lack of progress in rehabilitation. They remain silent and passive in society and their families keep the silence and mystery around their problems. In general, the causes, clinical expressions as well as prognosis and therapeutic options for the most common mental disorders are largely unknown by the general public. The social representations of mental illness are in essence mythical and governed by stereotypes (Corrigan et al., 2003; Foster, 2006).

Studies conducted in different cultural contexts emphasize the prevalence of stigmatizing attitudes towards mental illness. Authors like Corrigan, Green, Lundin, Kubiak and Penn (2001) illustrate the prevalence of prejudice towards mental illness in the general population in the United States. In addition, these authors show that the increase of public familiarity with serious mental illness, through the facilitation of social contact between members of the general public and persons who have serious mental illness, might decrease the stigmatizing attitudes towards this group of population. In a study conducted in Hong Kong, Chung, Chen and Liu (2001) emphasized the lack of willingness of university students to interact with a person labeled as mentally ill. According to these authors, greater social distance is associated with no previous contact with the mentally ill, non-medical field of study and female gender. More recently, Mahto and his collaborators (2009) have shown the ambivalent attitude expressed particularly by the female university students when they were questioned about sensitive issues related to persons with serious mental problems (on the Opinions about Mental Illness Scale, Cohen & Struening, 1962). This ambivalent attitude has been interpreted as an expression of a tendency observed in the general population to avoid as far as possible the issues related to mental illness. Besides these current data, reviewing the relevant literature in the field, the authors observe in recent years, at least in developing countries like India, an increase of the stigmatizing attitudes towards the mentally ill, accompanying an increase of the morbidity of mental disorders. An increase of the public negative attitudes toward mentally ill people has been observed in England and Scotland between 1994-2003, in a study conducted by Mehta and his colleagues (2009). In New Zealand, Kazantis, Wakefield, Deane, Ronan and Johnson (2009) have shown that older participants endorse more authoritarian, social restrictiveness and interpersonal ideology attitudes (assessed with the Opinions about Mental Illness Scale, Cohen & Struening, 1962) in their perception of people with mental illness compared with younger participants. According to the same authors, the attitudes toward people with mental illness in the general population are influenced by the opportunities to interact with this category of people in work settings. Similar studies were conducted in the last decade in many countries. In Romania, empirical data on this topic are extremely scarce. We are far from understanding how mental illness is perceived in our society, how difficult it is for the mentally ill people to be accepted in their professional field and to integrate in their community, or, if people stigmatize, how and why. In one of the few studies investigating mental illness stigma in Romania, Romanian adolescents scored low on familiarity with mental illness questionnaire and mental health literacy, and they believed that most people would devaluate or discriminate against a psychiatric patient. The adolescents included in the study group marginally reported fear and anger in relation with mentally ill patients, marginally endorsed responsibility and dangerousness stereotypes, but they strongly experienced pity, while manifesting acts of help, avoidance, coercion and segregation (Zlati, Oh, & Baban, 2001).

Stigmatizing attitudes towards mental illness, largely held in the general population in many countries, ultimately lead to various forms of social rejection and segregation of the people suffering from mental problems. Even in societies where an important amount of public and private funds are allocated for high quality psychiatric care services, the social expression of stigma and the lack of social support for the mentally ill patients can dramatically impede these efforts. The public opinions about mentally ill patients significantly affect their self concept, their willingness to seek professional help, the evolution of the illness, and their opportunities for social integration (Perlick, 2001; Freidl, Lang, & Scherer, 2003; Sartorius & Schulze, 2005). These negative consequences of mental illness stigma are sufficient reasons to justify the necessity to develop and implement efficient attitude change programs.

2. Aims

The present study examines the attitudes towards mental illness in a sample of university students from Romania. Using the Opinions about Mental Illness Scale (OMI; Cohen & Struening, 1962), a scale with a long history of usage in many different populations, five attitudinal dimensions were investigated: authoritarianism (the opinion that people with mental illnesses cannot be held accountable for their acts and they should be controlled by society), benevolence (an attitude that could be placed between tolerance and pity/compassion), mental hygiene ideology (the opinion that mental illness is similar to other illnesses and it should be treated adequately by specialists), social restrictiveness (the opinion that mentally ill persons should be restricted in some social domains), and interpersonal etiology (the belief that the real cause of a mental illness is problematic interpersonal relations). The rationale of this study was that the identification of beliefs underlying mental illness stigma could allow the future development of efficient and well-targeted anti-stigma programs.

3. Method

3.1. Participants

A total number of 150 undergraduate students from the University of Alba Iulia were included in this study. From this sample, 92 were girls and 58 were boys, aged between 18 and 32 years. They were selected from three different fields of study: Economics, Social Work and Orthodox Theology (Table 1). The existence of a family member or close friend suffering from a mental illness has been a criterion for exclusion from the study sample, and in these conditions, we expect that familiarity with mental illness is low for all the participants. The three subgroups differ regarding their mental health literacy: the students in Economics and Theology did not receive specific knowledge about mental illnesses through the faculty curriculum. The students in Social Work attended courses like *Psychopathology and Psychotherapy*, *Psychology*, *Deontology of Social Professions* and *Human Rights*, which could significantly influence their initial perspective on mental illness and their attitudes towards the mentally ill people. The students in Theology could represent a special case because of their ethical and humanistic values, firmly endorsed by the Orthodox Church.

Table 1. Socio-demographic data distribution across the three subgroups from the study sample

Groups	Number	Age	Gender	Area of residence
Economics students	80	18-32 (mean 19.6)	Girls: 69; Boys: 11	Urban: 58; Rural: 22
Social Work students	31	19-26 (mean 19.9)	Girls: 31; Boys: 0	Urban: 22; Rural: 9
Theology students	39	19-23 (mean 19.5)	Girls: 0; Boys: 39	Urban: 23; Rural: 16

3.2. Instruments

Participants' attitudes towards mental illness have been evaluated using the Opinions about Mental Illness Scale (OMI, Cohen, & Struening, 1962). The OMI scale was originally developed by Cohen and Struening in 1959 to assess the attitudes of health care personnel toward mental illness. According to the two authors, peoples' responses to the items on the OMI scale reflect their opinions and attitudes about the etiology, treatment and prognosis of mental illness. Construct validation of the OMI was done by using a pool of 200 items that were analyzed by more than 8000 people experienced in mental health, and a final form of the 51-item scale was derived from extensive factor analysis. The current form of the OMI scale consists of 51 opinion statements presented via a 6-point Likert-type scale. The response options range from 1 (Strongly Agree) to 6 (Strongly Disagree). Factor analysis of the 51 items revealed the following five subscales: Factor A: Authoritarianism (A, 11 items): the opinion that people with a mental illness cannot be held accountable for their acts and they should be controlled by society, Factor B: Unsophisticated Benevolence (UB, 14 items): an attitude that could be placed between tolerance and pity/compassion; Factor C: Mental Hygiene Ideology (MII, 9 items): the opinion that mental illness is similar to other illnesses and it should be treated adequately by specialists; Factor D: Social Restrictiveness (SR, 10 items): the opinion that mentally ill persons should be restricted in some social domains, and Factor E: Interpersonal Etiology (IE, 9 items): the belief that the real cause of a mental illness is problematic interpersonal relations. The OMI Scale has been chosen in this study because it has satisfactory psychometric properties and due to its long history of usage in different populations (Cohen & Struening, 1962; Kazantzis, 2009).

4. Results

The scores on the OMI subscales obtained by the students from the three different domains of study are presented in Table 2. Because on the 6-point Likert scale 1 = *Strongly Agree* and 6 = *Strongly Disagree*, in general, higher scores to a subscale reflect a more positive attitude.

Table 2. Scores on the OMI scale by field of study

Domain of study / OMI subscales	Economics		Social Work		Theology	
	Mean	*SD*	*Mean*	*SD*	*Mean*	*SD*
Authoritarianism	2.55	1.71	4.80	1.07	1.94	1.23
Benevolence	2.47	1.52	2.21	1.26	1.53	1.43
Mental Hygiene Ideology	2.85	1.22	4.72	1.60	3.67	1.12
Social Restrictiveness	3.49	1.17	2.55	1.21	2.80	1.32
Interpersonal Aetiology	4.15	1.53	5.03	1.72	4.14	1.40

Data collection indicates low scores (< 3) for most OMI subscales, in particular for the first three factors: A. Authoritarianism, B. Benevolence and C. Mental Hygiene Ideology, reflecting in general a less positive attitude towards mental illness held by all the participants. There are observable differences between the responses of the students from the three fields of study, reflecting the influence of their values and mental health literacy on their attitudes towards mental illness.

The Independent Samples t-test calculations indicate: significant differences between the mean scores obtained in Factor A: Authoritarianism by the students in Economics and Social Work ($t=7.78$, $p<.001$); significant differences between the mean scores obtained in Factor B: Benevolence obtained by the students in Economics and Theology ($t=3.59$, $p<.001$); significant differences between the mean scores obtained in Factor C: Mental Hygiene Ideology obtained by the students in Economics and Social Work ($t=6.05$, $p<.001$).

5. Discussion

Overall, the mean scores obtained by the students included in the study group are appreciated as being low (< 3) for Factors A, B and C: Authoritarianism, Benevolence and Mental Hygiene Ideology. In Factor E: Interpersonal Etiology, participants from all the subgroups reported higher scores.

In Factor A Authoritarianism, which assesses the opinion that people with a mental illness cannot be held accountable for their acts and they should be controlled by society, the lowest scores, reflecting a negative attitude, are obtained by the students in Theology. Their intolerance regarding this particular aspect of mental illness could be interpreted as a result of their low literacy in mental health and possibly of the persistence of dangerousness as a trait stereotypically associated with mental illness. By contrast, students in Social Work, having a higher level of literacy in mental health, registered significantly higher scores, reflecting a more positive attitude towards the ability of the mentally ill people to assume responsibility for their acts.

In Factor B Benevolence, the mean scores are low for all the three subgroups, reflecting an attitude that could be placed between tolerance and pity/compassion towards mental illness. The scores obtained by the students in Theology are significantly lower compared with those obtained by the students in Economics, probably as a result of their respect for tolerance as a basic human value associated with a low literacy about mental health. Tolerance and compassion are also values important for the practice of social work, but the students in Social Work, having a better literacy in mental illness, present slightly higher scores, reflecting a better understanding of metal illnesses.

In Factor C Mental Hygiene Ideology, which assesses the opinion that mental illness is similar to other illnesses and it should be treated adequately by specialists, students in Economic Sciences presents the lowest scores. The significantly higher scores registered by the students in Social Work reflect again their scientific perspective on mental health that contributed to attitude change. In the case of the students in Theology, their highest scores at this subscale could possibly reflect a stereotypical folk perspective about mental illness, which is regarded as having a rather obscure etiology.

In Factor D Social Restrictiveness, which assesses the opinion that mentally ill persons should be restricted in some social domains, the high scores registered by all the participants reflect their intolerant attitude towards mental illness. The most tolerant from the three subgroups are the students in Economics. In the case of the students in Social Work and Theology, their concern about social health and security, associated with the lack of scientific knowledge about mental illness, possibly generated this intolerance.

In Factor E Interpersonal Etiology, all the participants obtained higher scores (>3) reflecting a positive attitude. The participants from all the three subgroups seem to take into account a multiple and more complex etiology for mental illness.

These results argue for the necessity to understand mental illness in a broad social context. A better understanding of peoples' mental models of mental illness as well as a better understanding of the multiple social dimensions of stigma associated with mental illness will make possible the development of efficient and well-targeted anti-stigma programs.

References

Alonso, J., Angermeyer, M. C., Bernert, S., Bruffaerts, R., Brugha, T. S., Bryson, H., …Vollebergh, W. A. (2004). Prevalence of mental disorders in Europe: Results from the European Study of the Epidemiology of Mental Disorders (ESEMeD) project. *Acta Psychiatrica Scandinavica Supplement, 109*(420), 21–27.

Chung, K. F., Chen, E. Y., & Liu, C. S. (2001). University students' attitudes toward mental patients and psychiatric treatment. *International Journal of Social Psychiatry, 47*(2), 63-72.

Cohen, J., & Struening, E. L. (1962). Opinions about mental illness in the personnel of two large mental hospitals. *Journal of Abnormal and Social Psychology, 64,* 349–360.

Corrigan, P. W., Green, A., Lundin, R., Kubiak, M. A., & Penn, D. L. (2001). Familiarity with and social distance from people who have serious mental illness. *Psychiatric Services*, *52,* 953-958.

Corrigan, P., Markowitz, F., Watson, A., Rowan, D., & Kubiak, M. (2003). An attribution model of public discrimination towards persons with mental illness. *Journal Health Social Behavior*, *44,* 162-179.

Foster, J. L. H. (2006). Media presentation of the Mental Health Bill and representations of mental health problems. *Journal of Community and Applied Social Psychology*, *16,* 285-300.

Freidl, M., Lang, T., & Scherer, M. (2003). How psychiatric patients perceive the public's stereotype of mental illness. *Social Psychiatry and Psychiatric Epidemiology, 38*(5), 269-275.

Kazantzis, N., Wakefield, A., Deane, F. P., Ronan, K., & Johnson, M. (2009). Public attitudes toward people with mental illness in New Zealand, 1995-1996. *The Australian Journal of Rehabilitation Counseling*, *15*(2), 74-91.

Kessler, R. C., Chiu, W. T., Demler, O., & Walters, E. E. (2005). Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). *Archives of General Psychiatry*, *62*(6), 617-627.

Mahto, R. K., Verma, P. K., Verma, A. N., Singh, A. R., Chaudhury, S., & Shantna, K. (2009). Students' perception about mental illness. *Industrial Psychiatry Journal, 9*(18), 92-96.

Mehta, N., Kassam, A., Leese, M., Butler, G., & Thornicroft, G. (2009). Public attitudes towards people with mental illness in England and Scotland, 1994–2003. *British Journal of Psychiatry, 194,* 278–284.

Perlick, D. A., Rosenheck, R. A., Clarkin, J. F., Sirey, J. A., Salahi, J., Struening, E. L., & Link, B. G. (2001). Stigma as a barrier to recovery: Adverse effects of perceived stigma on social adaptation of persons diagnosed with bipolar affective disorder. *Psychiatric Services, 52*(12), 1627-1632.

Sartorius, N., & Schulze, H. (2005). *Reducing the stigma of mental illness. A report from a Global Programme of the World Psychiatric Association*. Cambridge: Cambridge University Press.

Zlati, A., Oh, J., & Baban, A. (2011). Mental illness stigma among Romanian adolescents. *Journal of Child and Adolescent Psychology*, *3,* 67-76.